PROPOSAL FOR A SECTION 1915(b)(4) Initial Selective Contracting Waiver Program

Waiver Application Form

This streamlined waiver application form, adapted from the Section (b)(1) waiver application by the Dallas Regional Office, is for a State's use in requesting implementation of an initial Section 1915(b)(4) Selective Contracting waiver program.

The State may wish to use this standardized application form to streamline the waiver process and, thus, eliminate unnecessary and cumbersome paperwork requirements. The completion of this request, used in conjunction with State Medicaid Manual instructions at sections 2106-2112, should expedite the State's effort to request a waiver and HCFA's effort to approve the waiver proposal. Where possible, the proposal is in the form of a check-off document. However, the applicant will be required to provide detailed explanations on appendices.

All waiver requests under Section 1915(b) of the Social Security Act (the Act) are subject to the requirements that the State document the cost effectiveness of the project, its effect on recipient access to services, and its projected impact (42 CFR 431.55(b)(2)). This model Section 1915(b)(4) waiver application form will help States provide sufficient documentation for the Secretary to be able to determine whether the statutory and regulatory requirements of Section 1915(b) of the Act have been satisfied.

The HCFA Regional Office will be glad to meet with the State, set up a conference call, or assist the State in any way to complete the application.

I. INTRODUCTION

On Appendix I, please provide a short narrative description, in one page or less, of your program, the background to your program and any other information relating to your request for a Medicaid waiver.

II. GENERAL DESCRIPTION OF THE WAIVER PROGRAM

A. The State of **Louisiana** requests a waiver under the authority of Section 1915(b)(4) of the Social Security Act (the Act). The waiver program will be operated directly by the Medicaid agency.

B. Effective Dates: This waiver is requested for a period of 2 years; effective 11/1/2002 and ending 10/31/04.

C. The waiver program is called Models of Excellence-Health Alliance Program for Asthma and Diabetic Pharmaceuticals and Supplies. See Appendix II.C for Models of Excellence Request for Proposal Overview

D. Geographical Areas of the Waiver Program:

The waiver will be implemented in the following areas of the State:

(1) XX Statewide

(2) _____ Other-than-Statewide (Cities and Counties are Listed on Appendix II.D.(2))

(Note: if the State wishes to alter the waiver area at any time during the waiver period, an official waiver modification must be submitted to HCFA.)

E. State Contact: The State contact person for this waiver is can be reached by telephone at 225-342-4775 (Sondra Burns).

F. Statutory Authority: The State's waiver program is authorized under ***Section 1915(b)(4) of the Act*** under which the State restricts the provider from or through whom a recipient can obtain medical care.

G. *Relying upon the authority of the above section(s), the State*

would like a waiver of the following Sections of 1902 of the Act:

1. ___ ***Section 1902(a)(1)*** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State. (See Appendix II. D.(2))

2. ___ ***Section 1902(a)(10)(B)*** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid recipients not enrolled in the waiver program.

3. XX ***Section 1902(a)(23)*** - Freedom of Choice--This section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, individuals in this waiver are constrained to receive waiver services from selected providers.

4. ___ ***Other Statutes Waived*** - In Appendix II.G.4, please list any additional section(s) of the Act the State requests to waive, including an explanation of the request.

H. Recipient Figures: Please indicate the expected number of Medicaid recipients that will be impacted by the waiver:
166,010

I. Waiver Populations: The waiver is limited to the following target groups of recipients. Check all items that apply:

1. X **AFDC** - Aid to Families with Dependent Children.

2. X **AFDC-Related**

3. X **SSI** - Supplemental Security Income and SSI-related.

4. X **Other** - Please describe these other populations on Appendix II. I.4.

J. Excluded Populations: The following recipients are excluded from participation in the waiver:

1. __X__ have Medicare coverage, except for purposes of Medicaid-only services;

2. __X__ have other insurance;

3. __X__ are residing in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF/MR);

4. __x__ have an eligibility period that is less than 3 months;

5. __x__ have an eligibility period that is only retroactive;

6. __x__ are eligible as medically needy;

7. __x__ are eligible as foster care children;

8. __x__ participate in a home and community-based waiver; or

9. __x__ have other reasons which may exempt recipients from participation under the waiver program. Please explain those reasons on Appendix II.J.9.

K. Distance/Travel Times: On Appendix II. K., please define your access standards for distance/travel times for recipients to receive services.

L. Independent Assessment: The State will arrange for an Independent Assessment of the cost-effectiveness of the waiver and its impact on recipient access to care of adequate quality. **This assessment is to be submitted to HCFA 6 months prior to the end of the waiver period**. Entities that may perform the assessment include universities, actuaries, etc. Examples of independent assessments are available upon request.

M. Automated Data Processing: Federal approval of this waiver request does not obviate the need for the State to comply with the Federal

automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C; 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

III. PROGRAM IMPACT:

In this section, please provide information on (1) affected recipients, (2) services, and (3) waiver providers.

A. Affected Recipients

1. Notification Process: On Appendix III. A. 1, please explain in detail the process through which recipients will be notified of the waiver program provisions.

2. ***Recipient's Choice of Providers.*** If more than one provider is selected per geographical area, please address the following points on Appendix III. A. 2:

Not Applicable (See III.A.2 for explanation)

(a) Will recipients be given the choice of selected providers? If so, how will they select a provider, and how will the provider be informed of the recipient's choice?

(b) How will beneficiaries be counseled in their choice of waiver providers?

(c) How will the recipient notify the State of provider choice?

(d) Define the time frames for recipients to choose a waiver provider.

(e) Will the recipients be auto-assigned to a waiver provider if they do not choose? Yes ____ No ____

(i) If so, how many days will they have to choose?

(ii) Describe the auto-assignment process and/or algorithm.

3. Implementation Process

(a) Will implementation occur all at once?

__ Yes

__X__ No. please describe on Appendix III. A.3.(a) the time frames for implementation, including time frames for inclusion of current Medicaid recipients.

(b) Will there be accommodations for special-needs populations such as the disabled, etc.?

__ Yes. Please explain on Appendix III. A.3.(b).

_X__ No

4. Education Materials: Please include on Appendix III. A.4 all relevant recipient education materials, including the **initial notification letter** from the State. Also, check the items which will be provided to the recipients:

a. ___x__ a **brochure** explaining the program

b. _NA__ if more than one provider is selected per geographical area, a **form** for selection of a provider

c. _NA__ If more than one provider is selected per geographical area, a **list of qualified providers** serving the recipient's geographical area;

d. ___ a ***new*** **Medicaid card** which includes the provider's name and telephone number or a ***sticker*** noting the provider's name and telephone number to be attached to the original Medicaid card (please specify which method);

e. ___**a brief presentation and informing materials** to each new recipient describing how to appropriately access services under the waiver program, including the appropriate usage of emergency rooms and family planning services, and how to exercise due process rights; and

f. ___ other items (please explain on Appendix III. A. 4.f.):

5. Languages. The State has made a concerted effort to determine if and where significant numbers (10% or more) of non-English speaking recipients reside, and has subsequently made the program educational materials available in the native languages of those groups.

B. Services:

1. Description of Services:

Please identify the Medicaid services which will be affected by the selective contracting process:

Asthma and Diabetic pharmaceuticals and supplies and durable medical supplies will be affected. See Appendix III.B.1 attached for further detail.

If additional space is needed, please create an Appendix III. B. 1.

2. *Emergency and Family Planning:* In accordance with regulations, freedom of choice of provider in cases of emergency and family planning services will not be restricted.

C. Selection and Availability of Providers

1. *Selection Criteria:* On Appendix C. 1, please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Included are the approximate weight associated with each of the criteria.

2. *Numbers and Types of Qualifying Providers:* For each of the services covered by the selective contracting waiver, please list on the chart below the numbers of Medicaid providers available to provide services to the waiver population. The chart also compares the number of providers expected under the waiver with what existed prior to the waiver.

For non-institutional services provided by an "entity" (i.e. versus an

independent practitioner), please provide information on Appendix III. C. 2. as to the numbers of actual care givers per entity that will be available to provide the waiver service(s).

SERVICE:

Provider Types	***Number of Medicaid Providers Participating Before the Waiver***	***Number of Medicaid Providers* <u>Expected</u> to Participate Under the Waiver**
DME	**384 in-state**	**One (1)**
Pharmacies	**1,083 in-state**	**One (1)**
3.		
4.		
5.		

6.		

3. Program Requirements. Below is a description of provider qualifications and requirements under the waiver. Providers **must**:

a. be Medicaid qualified providers and agree to comply with all pertinent Medicaid regulations and State plan standards regarding access to care and quality of service and meet general qualifications for enrollment as a Medicaid provider;

b. not refuse to provide services to a waiver participant or otherwise discriminate against a participant solely on the basis of age, sex, race, physical or mental handicap, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider type; and

c. ____other qualifications (explain on Appendix III. C. 3. c):

4. Provider/ Beneficiary Ratio: Please calculate and list below the expected average provider/beneficiary ratio for each geographical area or county of the program, and then provide a statewide average. *****This is a selective contracting contract; therefore, one provider will provide services except for initial prescription for newly diagnosed recipients and emergency prescriptions.***

Area (City/County/Region)	***Provider-to-Beneficiary Ratio***	
	Without the Waiver	***Under the Waiver***

DHH ADMINISTRATIVE REGIONS - The administrative regions within the Department of Health and Hospitals comprised as follows: ***Region 1*** - Jefferson, Orleans, Plaquemines, and St. Bernard; ***Region 2 -*** Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, West Feliciana; ***Region 3*** - Assumption, Lafourche, St. Mary, St. James, St. John, St. Charles, and Terrebonne; ***Region 4*** - Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, and Vermilion; ***Region 5*** - Allen, Beauregard, Calcasieu, Cameron, Jefferson Davis; ***Region 6 -*** Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, and Winn; ***Region 7*** - Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine, and Webster; ***Region 8*** - Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Richland, Ouachita, Tensas, Union, and West Carroll; and ***Region 9 -*** Livingston, St. Helena, St. Tammany, Tangipahoa, and Washington.		
Region 1	Pharmacy-221 DME- 84	1
Region 2	Pharmacy-133 DME- 47	1
Region 3	Pharmacy—91 DME-23	1

Region 4	Pharmacy -162 DME- 55	1
Region 5	Pharmacy - 72 DME- 20	1
Region 6	Pharmacy - 87 DME- 39	1
Region 7	Pharmacy -111 DME- 50	1
Region 8	Pharmacy -107 DME- 29	1
Region 9	Pharmacy - 99 DME- 37	

Statewide Average: (e.g., 1:500, 1:1000)

5. ***Change of Provider:*** Please answer the following questions regarding beneficiary changes of providers and/or actual care givers:

    a. *Change of Providers:*

If there is more than one selected provider per geographical area, can the beneficiaries change providers?

Not Applicable **This is a selective contracting contract; therefore, one provider will provide services except for initial prescription for newly diagnosed recipients and emergency prescriptions.

____ No

_____Yes . Please describe on Appendix III. C. 5. a. the process, reasons, etc.

b. *Change in Actual Care Givers:*

Not Applicable **This is a selective contracting contract; therefore, one provider will provide services except for initial prescription for newly diagnosed recipients and emergency prescriptions.

(I) For non-institutional waiver services provided by an "entity," can the beneficiaries change their individual care givers within the selected provider?

____ No

_____Yes . Please describe on Appendix III. C. 5. b. the process, reasons, frequency, etc.

6. Provider's Change of Beneficiary: Please answer the following questions regarding provider changes of beneficiaries:

a. If more than one provider is selected per geographical area, can providers request to reassign a beneficiary from their care?

Not Applicable **This is a selective contracting contract; therefore, one provider will provide services except for initial prescription for newly diagnosed recipients and emergency prescriptions.

No _____

Yes

If yes, **it is important that reasons for reassignment are not discriminatory in any way toward the patient**. In cases of

beneficiary change, the reassignment should be agreed upon by the beneficiary as well. The following are acceptable reasons for reassignment. Please check the ones that apply to the State's program and explain those that differ:

Not Applicable **This is a selective contracting contract; therefore, one provider will provide services except for initial prescription for newly diagnosed recipients and emergency prescriptions.

(1) __ patient/provider relationship is not mutually acceptable;

(2) __ patient's condition or illness would be better treated by another provider type; or

(3) __ Other reasons (explain on Appendix III. C. 6.a):

b. ***If the reassignment is approved,*** the State must notify the beneficiary in a direct and timely manner of the desire to remove the beneficiary from his/her caseload, and must keep the participant as a client until another provider is chosen or assigned. Please specify on Appendix III. C. *6.b.* if the State's policy differs in any way from those listed above.

7. Reimbursement of Providers: Under this waiver, providers are reimbursed on the following basis:

___X___ fee-for-service

_____ capitated

IV. ACCESS TO CARE AND QUALITY OF SERVICES:

A. General: The beneficiary's access to quality medical services must at a minimum not be adversely affected by a 1915(b)(4) waiver program. A waiver must assure an adequate amount of services during reasonable time periods and within reasonable geographic distance from the residences of the individuals enrolled under the waiver. Furthermore, access to emergency services and family planning services must not be restricted. See Appendix IV.A

B. Grievance Process: On Appendix IV. B., please describe the process that will be in place to handle complaints and grievances under the waiver

program. Please discuss how this will compare to the regular Medicaid program. ***NOTE: Beneficiaries must have available and be informed of a formal appeals process under 42 CFR Part 431, Subpart E which may lead to a Fair Hearing.*** Please fully describe on Appendix IV. B.

C. Monitoring Access:

1. **Service Access Areas:** On Appendix IV. C. 1, please explain in detail the State's plans to monitor and improve the following areas of service access:

   a. time and distance

   b. waiting times to obtain services

   c. provider-to-beneficiary ratios

   d. beneficiary knowledge of how to appropriately access waiver services

   e. access to emergency services

2. **Procedure for Monitoring:** *Beneficiary access to care will be monitored during the waiver period by the State as indicated below. Records will be maintained to identify lack of access trends and for reporting purposes. Check which monitoring activities will be in effect to assure that beneficiary access to care is not substantially impaired. Also, on Appendix IV. C. 2, identify the means the State will employ to intervene to correct problems. If any of the following differ from the State's program, please indicate and explain on Appendix IV. C. 2:*

   a. ____ **An advisory committee** will be designated during the phase-in period to address beneficiary and provider concerns.

   b. __X__ **A Hotline** with an 800 number will be maintained which handles any type of inquiry, complaint, or problem. A regular will be provided.

   c. ____ **Periodic comparison** of the numbers of providers available to the Medicaid recipients before and under the waiver will be conducted. The intent of this review is to identify whether the waiver may have reduced access to specific types of providers. Also, for non-institutional services,

a periodic comparison will be made of the individual care givers within an "entity", where applicable, in order to ensure that the same level of access is maintained throughout the waiver period.

d. _X_ **Periodic beneficiary surveys** (which will contain questions concerning the beneficiaries' access to all services covered under the waiver) will be mailed to a sample of waiver recipients.

e. ___ **Other** (explain on Appendix IV. C. 2. e.)

D. Monitoring Quality of Services: On Appendix IV. D, please explain in detail the State's plans to monitor and assure quality of services under the waiver program. Please describe how will the State monitor the following:

1. **Beneficiaries' reasons for changing providers** in order to detect quality of care problems (not only actual changes, but requests to change specific individual care givers and/or providers);

   Not Applicable **Exclusive contract resulting from a Request for Proposal process.

2. **Hotline**

3. **Periodic beneficiary surveys** (which question the quality of services received under the waiver) are mailed to a sample of waiver recipients;

4. **Complaints**, grievance and appeals system;

5. **Other** (explain on Appendix IV.D.5.).

E. Other Quality Monitoring:

1. **Quality of Services** will be further monitored through the mechanisms outlined in Appendix IV. E. 1. In addition, Contractor agrees to the terms and conditions as specified in the RFP, "Part Two, Scope of Work, ILL. Required Components, B. Quality Improvement for Products," as well as the Requirements in the Reference Materials of the RFP (Guidelines for Developing Quality Improvement Plans, Durable Medical Equipment (Attachment E of the contract). The Quality Improvement Plan for

Pharmaceuticals will model Contract-Attachment E; however, Contractor agrees that the DHH may include or require additional quality improvement requirements in the areas of performance measures, monitoring components and reports specifically for pharmaceuticals. Timelines for additional quality improvement requirements will be determined by the DHH.

Quality of services problems identified will result in a desk review or an onsite review to resolve the problems.

2. **Periodic reviews**: On Appendix IV. E. 2, please describe what areas will be covered in the State's periodic reviews of claims files and medical audits, including the types of care reviewed and how the problems will be resolved. Please include how often these reviews will take place.

3. ***State Intervention:*** If a problem is identified regarding access to care and quality of services problems, the State *will intervene* as noted below (please indicate which of the following the State utilizes:

   a) __X__ Education and informal mailing

   b) __X__ Telephone and/or mail inquiries and follow-up

   c) __X__ Request that the provider respond to identified problems

   (d) __X__ Referral to program staff for further investigation

   (e) __X__ Warning letters

   (f) __X__ Referral to State's medical staff for investigation

   (g) __X__ Corrective action plans and follow-up

   (h) _____ Change beneficiary's provider

   (I) __X__ Restriction on types of beneficiaries

   (j) __X__ Further limits of the number of assignments

   (k) __X__ Ban on new assignment of beneficiaries

(l) _____ Transfer of some or all assignments to a different provider

(m) ___X___ Suspension or termination as a waiver provider

(n) ___X__ Other (explain on Appendix IV. E. 3. n).

V. COST EFFECTIVENESS:

A. General: *In order to demonstrate cost effectiveness, a waiver request must show that the cost of the waiver program will not exceed what Medicaid's cost would have been in the absence of the waiver. The cost-effectiveness section provides a methodology to demonstrate that the waiver program will be less costly than what costs would be without the waiver.*

The State should use its Medicaid fee-for-service experience to develop the cost-effectiveness section of the waiver program. When submitting an initial 1915(b)(4) waiver, the State should estimate the cost of providing the waiver services under the waiver and provide a comparison to the projected cost without the waiver. The costs under the waiver may be estimated based on responses to a request for proposals (RFP) from the potential contractors. The amount of the savings may be estimated based on the discount from the State Plan rates represented by the RFP bids. To project the net savings, the State should add any additional costs associated with administering the waiver, to the projected costs of delivering the waiver services under the waiver. This amount should be compared to the costs of delivering the services without the waiver. All cost comparisons should be made separately for each year of the waiver.

B. Rationale for Expected Cost Savings: On Appendix V. B., please explain the State's rationale for expected cost reductions under the waiver program. Include all assumptions made regarding changes due to inflation, utilization rates, State Plan payment rates, and other factors.

C. Format for Showing Savings Summary
(Include supporting documentation, i.e., charts, spreadsheets, in Appendices V.C.)

1. ***The following schedule shows the calculation of the State's program benefit costs under the waiver (if these are not applicable to the State's methodology, please attach the calculations).***

Cost Saving Category	***Costs Expected Without the Waiver***	***Projected Percentage of Cost Savings***	***Total Benefit Savings***
Asthma Drugs	$50,430,645	8.54%	$4,308,955
Diabetic Drugs	$6,866,113	6.24%	$428,442
Diabetic Supplies	$116,402	99.95%	$116,348
TOTAL	$57,413,160	8.45%	$4,853,745

2. Costs Under the Waiver

a. Total waiver costs are expected to be $ 54,958,679 during the 2-year waiver period. This includes $ 52,559,415 in program benefit costs and $ 2,399,264 in additional costs (management fees, administrative costs, bonus payments if any, etc.) which would not have been incurred had the waiver not been implemented.

3. ***Additional Waiver Costs***

The following additional costs are expected to occur under the waiver:

(a) Total additional administrative costs under the waiver, which would not be incurred if the waiver was not implemented, are expected to be $ 2,399,264

(b) Additional administrative costs are broken down as follows and a brief explanation of each cost item is included on Appendix V. C. 3.(b):

(1) X Contract Administration $ 156,264

(2) X Systems Modification $ 2,000,000

(3) ___ Outreach conducted by State employees.

(4) ___ Beneficiary Education, $____
Outreach conducted by contracted entity;

(5) ___ Handling Complaints, $____
Grievances and Appeals.

(6) ___ Utilization Review System $200,000 Independent review

(7) ___ Additional Staff $

(8) ___ Hotline Operation $

(9) X Quality Assurance Review System $ 40,000 (pharmacist)

(10) ___ Outreach, Education and Enrollment of Waiver Providers $

(11) X Other (explain) $3,000
Notices to physicians and pharmacies

4. Costs Without the Waiver

The State projected what the costs would be without the waiver by first calculating the costs during the fiscal year (*2000*) prior to the waiver period. These base year cost data were then projected forward, adjusting for changes in utilization, characterization of affected beneficiaries, changes in payment rates or methodologies and changes in other State policies, to determine what costs would be without the waiver in effect during the proposed 2-year waiver period. The documentation to demonstrate what costs would be in the absence of the waiver is presented in Exhibit 1.

5. Program Savings

The schedule below shows how savings were calculated under the waiver:

Year	*Cost Reductions Expected Under the Waiver*	*Minus: Total Additional Waiver Costs*	*Program Savings*
2003	$2,069,735	$1,599,600	$470,135
2004	$2,784,009	$799,664	$1,984,345
Total	$4,853,744	$2,399,264	$2,454,480

Exhibit 1 - Costs With and Without the Waiver

See attached Rationale for Expected Cost Savings

Column Explanations for Exhibit 1

Costs without the Waiver (year 1 - SFY 2003)

A. Therapeutic Classes of drugs and procedure codes
B. Total number of persons who meet criteria to be included in potential population (excluding elderly, Medicare, Medically Needy, etc) not including diagnosis of Asthma or Diabetes. Calculated on Pop-Phar worksheet.
C. % of Eligibles using, derived from "Percent of Eligibles Using" on Pop-Phar worksheet.
D. # Users, calculated by multiplying Column B by Column C.
E. Services per User, calculated on Svcs-Phar.
F. Total # Services, calculated by multiplying Column D by Column E.
G. Cost without the Waiver, Calculated by multiplying Column F by Column H.
H. Average Cost per Service without waiver Calculated on Svcs-Phar.

Costs With the Waiver (year 1 - SFY 2003)

I. % Savings estimated from fiscal intermediary costing out payment by therapeutic class using current methodology and by applying bidder's proposed methodology. The calculation is demonstrated on Percent Reductions using Health Alliance Proposed Methodology.
J. Cost with Waiver calculated by multiplying Column K by Column F.
K. Average Cost per Services with waiver calculated by subtracting Column H times Column I from Column H.
L. Savings per Service calculated by subtracting Column K from Column H.
M. Total savings calculated by subtracting Column J from Column G.

Costs without the Waiver (year 2 - SFY 2004)

P. Therapeutic Classes of drugs and procedure codes
Q. Total number of persons who meet criteria to be included in potential population (excluding elderly, Medicare, Medically Needy, etc) not including diagnosis of Asthma or Diabetes. Calculated on Pop-Phar worksheet.
R. % of Eligibles using, derived from "Percent of Eligibles Using" on Pop-Phar worksheet.
S. # Users, calculated by multiplying Column B by Column C.
T. Services per User, calculated on Svcs-Phar.
U. Total # Services, calculated by multiplying Column D by Column E.
V. Cost without the Waiver, Calculated by multiplying Column F by Column H.
W. Average Cost per Service without waiver Calculated on Svcs-Phar.

Costs With the Waiver (year 2 - SFY 2004)

X. % Savings estimated from fiscal intermediary costing out payment by therapeutic class using current methodology and by applying bidder's proposed methodology. The calculation is demonstrated on Percent Reductions using Health Alliance Proposed Methodology.

Y. Cost with Waiver calculated by multiplying Column K by Column F.

Z. Average Cost per Services with waiver calculated by subtracting Column H times Column I from Column H.

AA. Savings per Service calculated by subtracting Column K from Column H.

AB. Total savings calculated by subtracting Column J from Column G.

APPENDIX I

Introduction

The Models of Excellence-Health Alliance Program for Asthma and Diabetic Pharmaceuticals and Supplies is a result of a broad-based Request for Proposals (RFP) for “models of excellence’ for alternative health care delivery systems for Medicaid services to provide more efficient and effective delivery of services.

Health Alliance was one of four respondents to the RFP and all responses were exclusive in that no response duplicated the response of another proposer.

Health Alliance proposed to provide mail-order pharmaceuticals and supplies for Medicaid recipients requiring these and also some disease education for these conditions. The products are provided at a discount over the regular Medicaid fee-for-service rate. See attached contract for further information.

This is similar to a program that Health Alliance has undertaken in Florida under a 1915(b) waiver. The program is expected to provide added convenience to recipients as well as monitoring of compliance with medication usage instructions and disease education.

Appendix II.C Overview of Models of Excellence Request for Proposals

A Models of Excellence Request for Proposals (RFP) was issued April 3, 2000, seeking pilot programs for alternative delivery of Medicaid services. Four models were included in the RFP as examples but other models could be proposed. The four models were:

1. Selective Contracting for Products such as durable medical equipment;
2. Global Surgical Packages including hospital and physician costs for surgeries such as cardiac or transplant surgeries similar to Medicare's model;
3. Disease Management Only including education of providers and recipients, coordination and follow-up for a specific disease to result in better management by the provider and patient for improved health outcomes with the contractor sharing in any resulting savings with DHH; and
4. Disease Management-Center of Excellence with provision of a continuum of medical services related to care of patients with the specified disease, similar to an HMO model of health delivery.

Model number 4 was eliminated before the proposal submittal deadline. On June 29, 2001 the Department received four (4) non-competing and non-duplicative proposals. Three were awarded contingent contracts on December 5, 2001under the Selective Contracting model. One proposes to provide radiation therapy/oncology services and another proposes to provide injectables such as chemotherapy drugs, growth hormone, blood products/factors, etc. Health Alliance, the third proposal and subject of this waiver, proposes to provide pharmaceuticals and supplies for diabetes and asthma.

II.D. (2) The program will a phase-in implementation over six to twelve month period.

II.I.4 This waiver is limited to recipients who are Medicaid eligible who are AFDC-related and SSI-related but not receiving long term care services (i.e. in an institution or receiving Home and Community-based Waiver Services), not also Medicare eligible, or eligible for less than three months, and who meet the following criteria:

> a diagnosis of asthma or diabetes and require medications and/or supplies for either condition;

II.J.9 Recipients who have been identified and are restricted to a specific pharmacist and/or physician through the Drug Utilization Review Program.

II.K Recipients receive services in their home as asthma pharmaceuticals and diabetes pharmaceuticals and supplies are mailed to the recipient's home or other designated location from a central warehouse located in Louisiana. Pharmaceuticals, insulin and syringes are to be delivered within 24 hours from request with second-day delivery for glucose testing supplies. The provider is accessible for questions or concerns via a toll-free hotline.

APPENDIX III

III.A. 1

Notification Process

All households with recipients meeting the criteria will receive a letter from the Department of Health and Hospitals explaining the program and describing the process for obtaining services. The letter will also provide other information and list the toll-free hotline number. The contractor, an enrolled Medicaid provider, will maintain and ship pharmaceuticals and products from a warehouse in Baton Rouge except in state declared emergencies when it may be necessary to ship from the contractor's headquarters in Deerfield, Illinois. This is similar to a 1915(b) waiver in Florida.

There will be articles regarding the Health Alliance program in the Provider Update, Louisiana's fiscal intermediary's quarterly newsletter and in the remittance advice.

DHH shall identify all Medicaid eligibles meeting the program criteria and generate a listing of these to be provided to Health Alliance.

Health Alliance will then send a letter to all eligibles referred to them by DHH, explaining the program and asking the recipient for information and appropriate authorizations. Health Alliance will then forward contact the physician(s) and request a prescription for the pharmaceuticals/supplies to be provided under this contract.

When Health Alliance receives the prescription, the pharmaceuticals/supplies will be mailed within timelines defined above. Provisions exist for emergency circumstances when the recipient needs the medicine immediately. Both providers and recipients will be provided information for filling emergency prescriptions.

Health Alliance will monitor the utilization of medications/supplies and contact recipient when a new supply would be needed to verify that it is indeed needed. Health Alliance will also provide a toll-free hotline staffed by appropriately trained professionals to answer recipient questions, request additional information or otherwise address recipient concerns.

III.A.2 This was a selective contracting process; therefore, one (1) provider was selected to provide these services statewide.

III.A. 3(a) Implementation will be a phase-in over a six to twelve month period.

III.A.4 See Contractor's proposal which is Attachment C of the Contract.

III.B.1 The list in Contractors proposal of asthma and diabetic pharmaceuticals and supplies and durable medical equipment and supplies has been modified. Contractor will only supply the pharmaceuticals and supplies as well as testing supplies for diabetics.

III.C.1 Provider was selected through a Request for Proposals process, but the scope of work proposed was not duplicated by any other proposer. Thus, qualifications specified in the RFP were utilized to determine if proposer met these requirements. See RFP (Attachment B of contract for requirements, selection criteria and related points).

APPENDIX IV. Access To Care and Quality of Services

IV.A. General

This waiver provides for delivery of pharmaceuticals and supplies via mail to the homes of Medicaid recipients who have asthma or diabetes and require these products. This is a new service to be offered by Louisiana Medicaid. Contractor will not be allowed to drop ship pharmaceuticals or supplies. Contractor will provide disease education at no cost. This program will not require recipients to leave their homes in order to obtain these Medicaid services, and, in fact, may provide greater access for recipients with transportation and mobility restrictions. Thus, geographic distance is not a factor. Also, this waiver does not impede access to emergency services and family planning services.
Recipients needing emergency pharmaceuticals and supplies will access them according to existing DHH procedures which allows them to present a prescription for emergency pharmaceuticals and supplies to any licensed provider. The prescription can be filled and a claim made for payment indicating an emergency filling of the prescription. There is an override in the billing system that will allow for emergency dispensation with no impediment to recipient access. Monitoring for utilization will be done on a monthly basis.

IV.B. Grievance Process

The State will work with contractor to develop corrective action procedures to ensure resolution of all problems/complaints identified through the grievance process. All correspondence to recipients will be required to include information regarding who to contact to file a complaint, grievance or appeal. Contractor has a process for forwarding complaints to the Contractor's CEO within 24 hours and resolving any problems and concerns within forty-eight (48) hours of receipt. Contractor is required to report complaints to the State. Contractor is required to adhere to the grievance process as outlined in the RFP.

The Department's Bureau of Appeals provides fair hearings for persons for whom Medicaid covered service(s) have been denied, suspended, reduced or terminated.

IV.C. Procedure for Monitoring

IV.C.1 Service Access Areas

a. time and distance
Not applicable

b. waiting times to obtain services

Pharmaceuticals, insulin and syringes are to be delivered within 24 hours from time of request and second-day delivery for glucose testing supplies. Review of customer satisfaction responses will be done on a monthly basis to identify deficiencies and implement corrective action if necessary.

c. provider-to-beneficiary ratio
Not Applicable (Selective Contractor-one contractor/provider)

d. beneficiary knowledge of how to appropriately access waiver
All households with recipients with target diagnoses and requiring related pharmaceuticals and supplies will be sent an initial notification letter describing the Health Alliance program. There will be a hotline set up for recipients to ask questions about the process or any other concerns.

e. access to emergency services
There will be no impact to recipients' ability to access emergency services.

IV.C.2 Procedure for Monitoring

DHH program staff will take complaints from recipients. Claims will be reviewed on a monthly basis and checked for proper access to services and compliance with contract requirements. The state will intervene to correct an established pattern of problems through the use of various sanctions including monetary fines, suspension of referrals to contractor, de-linking of recipients to contractor, etc. DHH staff will review all grievances/complaints related reports and communication logs to ensure enrollee access to timely services.

IV.D. Monitoring Quality of Services

1. Beneficiaries Reason for Changing Providers

Not Applicable (Selective Contracting-one contractor/provider)

2. Hotline

DHH will have the capability of "listening in" on hotline calls and will also survey recipients in regard to their interactions with the contractor,
and to take complaints.

3. Periodic Beneficiary Surveys

DHH will conduct periodic beneficiary surveys regarding satisfaction with provision of services by Contractor.

4. Contractor will provide DHH with a monthly summary report of recipient/prescribing provider complaints/complaints resolution as well as patient satisfaction data as requested. Contractor is required to copy the Department upon receipt of all complaints to assure timely intervention by the Department.

IV.E.1 Other Quality Monitoring

DHH will develop a Quality Improvement plan in conjunction with the Contractor to include performance indicators and outcomes measures. (See Attachment E of the contract for sample).

IV.E.2

Pharmacist consultant will conduct periodic claims review to assume appropriateness of dispensed pharmaceuticals, equipment and supplies. A corrective action plan will be developed and sanctions applied as appropriate.

APPENDIX V. Cost Effectiveness

V.B.

Cost reductions for prescription drugs were calculated by multiplying the estimated number of services by average cost without the waiver, then applying the calculated percent savings. This calculation was performed for each therapeutic class. The percent reduction for each therapeutic class was derived by having the fiscal intermediary capture one year's actual payment amounts for asthma and diabetes drugs by therapeutic class, then calculating payment using the payment methodology proposed by the successful bidder. The percentage differences were applied to their respective therapeutic classes. An explanation of derivation of the factors in each column is found in Exhibit 1, and the actual calculation is found on the spreadsheet, which is found in hard copy attached.